kaiser commission on medicaid and the uninsured

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Medicaid Medically Needy Programs: An Important Source of Medicaid Coverage

INTRODUCTION

Thirty-five states plus the District of Columbia operate medically needy programs.[1] This option allows states to provide Medicaid to certain groups of individuals who are not otherwise eligible for Medicaid. Certain groups of people, such as those who receive Temporary Assistance for Needy Families (TANF) benefits or Supplemental Security Income (SSI)—federal cash assistance benefits—generally are automatically eligible for Medicaid coverage. The medically needy option was originally established to provide a pathway to Medicaid coverage for people who have extensive health care needs, yet who start out with too much income to receive cash assistance benefits, and, thus, in the past, were often ineligible for Medicaid. In the 1980s and 1990s, Congress created several new state options for expanding Medicaid eligibility that now exist alongside the medically needy option. While the role of the medically needy option has evolved as states have gained additional tools for expanding coverage, it remains an important option that provides a "last chance" opportunity for becoming eligible for Medicaid.

Today, the medically needy program is used by states to expand coverage primarily to two groups: (1) Low-income young adults aged 19-20 and parents in states where the medically needy program is either the only eligibility category for these individuals or where the medically needy program has the highest maximum allowable income for Medicaid eligibility; and (2) Persons who spend down by incurring medical expenses so that, after medical expenses, their income falls below a state-established medically needy income limit (MNIL). The opportunity to spend down is particularly important to elderly individuals residing in nursing facilities and children and adults with disabilities who live in the community and incur high prescription drug, medical equipment, or other health care expenses. This issue brief provides an overview of the medically needy program; describes how it works for persons with disabilities, the elderly, and low-income families; and highlights some key issues surrounding the program. Included in the paper are hypothetical examples of ways in which individuals can qualify for the medically needy program and are intended for illustrative purposes only.

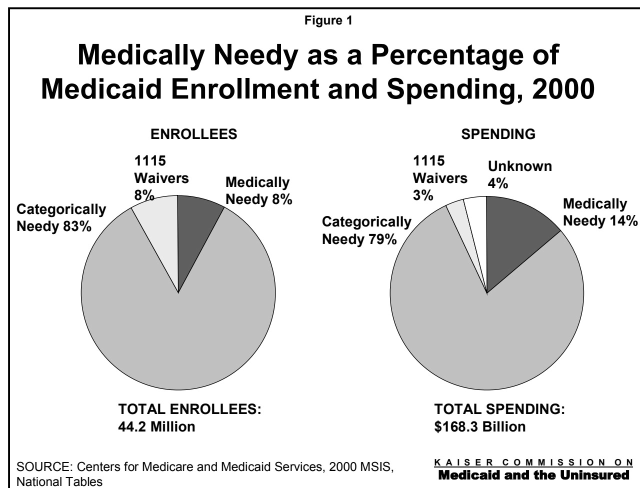
ENROLLMENT AND SPENDING IN THE MEDICALLY NEEDY PROGRAM

In 2000, Medicaid medically needy programs assisted 3.6 million people at a total cost of nearly $24 billion.[2] While Congress has established numerous other state options for expanding Medicaid coverage, the medically needy option is unique. States are required as a condition of receiving federal Medicaid support to provide coverage to certain categories of people, called "mandatory" populations. States also have broad

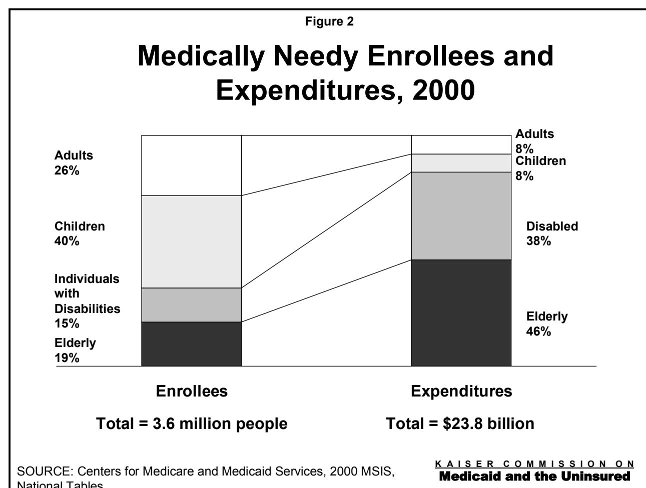
1330 G Street NW, Washington, DC 20005
Phone: 202-347-5270, Fax: 202-347-5274, Publications: 1-800-656-4533
Website: www.kff.org

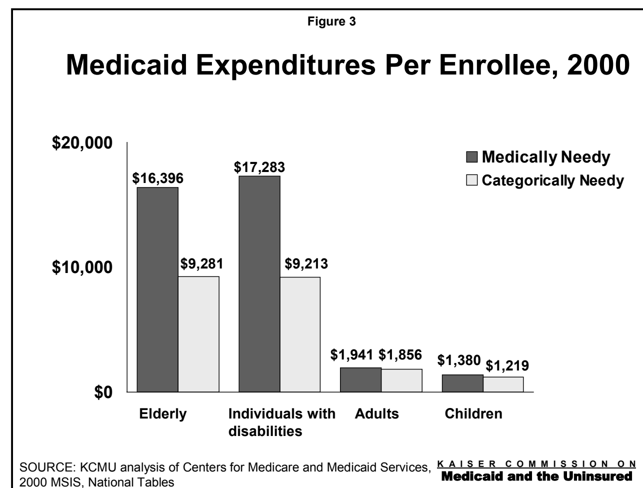
flexibility to go beyond federal minimum standards to cover numerous “optional” populations, for which they also receive federal matching payments.[3, 4] The medically needy population is one of these optional populations. Medicaid considers all mandatory and optional populations, except for medically needy beneficiaries, to be “categorically needy” and states are generally required to provide the same benefits to all categorically needy individuals. However, states have far more discretion in adopting more restrictive eligibility standards and in providing more limited benefits to the medically needy.

Representing 8 percent of all Medicaid beneficiaries, medically needy beneficiaries account for 14 percent of all Medicaid spending (Figure 1).[5] Medically needy beneficiaries who qualify by spending down, particularly those who are elderly or disabled, qualify for Medicaid because they incur high medical or long-term care expenses. Thus, they account for a disproportionate share of Medicaid spending.

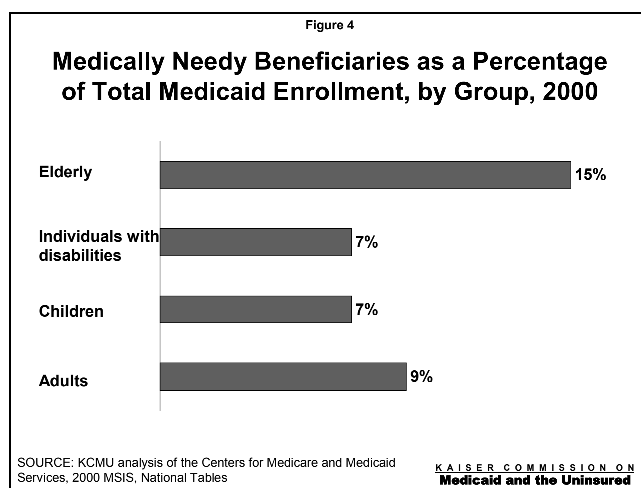


Children and their parents accounted for the majority (66%) of medically needy beneficiaries in 2000 (Figure 2). More than 1.4 million non-disabled children and more than 940,000 non-disabled adults qualified through the medically needy pathway.[6] The elderly and people with disabilities, however, are the cost drivers of medically needy programs, accounting for 84% of the $23.8 billion in federal and state spending in 2000. The elderly were responsible for $10.9 billion of medically needy spending and non-elderly people with disabilities were responsible for $9.1 billion of medically needy spending.[7] In FY 2000, per capita costs for covering medically needy elderly and people with disabilities averaged $16,396 and $17,283, respectively (Figure 3). This was nearly double the per capita cost for elderly and disabled categorically needy beneficiaries, which were $9,281 and $9,212, respectively. However, the per capita cost of covering medically needy children and parents ($1,380 and $1,941, respectively) were similar to categorically needy children and parents, $1,219 and $1,856.[8]





The medically needy option plays a large role for elderly Medicaid beneficiaries, accounting for 15% of overall elderly enrollment (Figure 4). This large share of elderly enrollment reflects the program's role in helping elderly individuals pay for nursing home costs. Medically needy coverage also is important to people with disabilities because it provides Medicaid coverage to poor and moderate-income beneficiaries who are ineligible for categorically needy Medicaid because their income (Social Security Disability Insurance (SSDI) payments or private pensions) is too high. The program plays a different role for non-disabled children and adults, who typically qualify based on having a low-income or health care costs related to an accident or severe illness.



HOW DO THE MEDICALLY NEEDY QUALIFY FOR MEDICAID?

States are permitted to offer medically needy coverage as an option and receive federal matching funds for payments made on behalf of beneficiaries who qualify for coverage. Federal matching funds are typically only available to cover people who fall into certain categories, broadly defined as children and their parents, people with disabilities, and the elderly. For each "categorical needy" eligibility group, the federal government sets minimum income and resource eligibility standards, although states are given the option to cover people with more income or resources. With the exception of pregnant women and children, Medicaid income levels traditionally have been set below the poverty level, with most states basing income and resource limits on cash assistance levels. Since 1986, states have had the option to expand access to Medicaid for people with disabilities and the elderly up to the poverty level and 17 states have done so.[9]

The medically needy option enables states to provide Medicaid coverage to individuals who meet the categorically needy eligibility requirements, but exceed the income standards. States can also use this option to extend children's coverage up to age 21. The option does not permit states to provide Medicaid to individuals who are not categorically needy, regardless of how poor they are or how extensive their medical needs. Thus, adults without children are generally not able to qualify for medically needy coverage, unless they are pregnant or disabled.

There are two ways individuals can become eligible for medically needy Medicaid. Individuals with income below medically needy levels, but above categorically needy income levels are eligible under the medically needy option. Individuals with higher incomes who meet a "spend-down" obligation can also qualify for coverage. Spend-down is met when, after deducting medical expenses from income, a person's remaining income is below the state's MNIL. Under the medically needy pathway, the individual's incurred medical costs are deducted from income over a period of one to six months (depending on the state). If, after deducting medical costs, the individual's income is below the state established MNIL, the individual will qualify for Medicaid coverage for the remainder of the period. This eligibility pathway can provide access to Medicaid coverage for individuals with recurring drug and medical expenses that are high in relation to their monthly income.

Federal rules require that state MNILs be no higher than 133% of the maximum state Aid to Families and Dependent Children (AFDC) level, as of July 16, 1996, for a family of the same size.[10] Although AFDC was replaced in 1996 by the Temporary Assistance to Needy Families (TANF) program, Medicaid MNILs remain linked to the old AFDC standards. Nonetheless, the MNIL cap can rise if the state increases its TANF income standards. States can increase the MNIL as family size increases, but they are not allowed to decrease it as family size increases.[11] States can also have different MNILs for urban and rural areas, taking into consideration differences in housing costs.[12]

Resource limits are often the same as those used in the Supplemental Security Income (SSI) program, with 20 states setting resource limits at $2,000 for individuals and $3,000 for couples. States are permitted to use less restrictive methodologies in counting income and resources under the medically needy program than under the SSI program, but they may not be more restrictive (see Appendix 1 for a more detailed explanation).

In 11 states, known as 209(b) states, Medicaid eligibility rules for people with disabilities and the elderly are slightly different from the federal SSI program—and some people who receive SSI do not qualify for Medicaid. When the Congress enacted the SSI program in 1972, it allowed states to use their 1972 state assistance eligibility rules for determining Medicaid eligibility in place of the federal SSI eligibility rules.[13] In 209(b) states, both the financial and non-financial eligibility criteria can be more restrictive than the federal standard, as long as they are no more restrictive than the rules they had in place in 1972. The states with 209(b) programs are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.[14] In these states, people with disabilities and the elderly must be given the opportunity to spend down to the state's income standard for mandatory eligibility, whether or not the state permits spend-down through a medically needy program.[15] In 209(b) states that also have medically needy programs (all 209(b) states except Indiana, Missouri, and Ohio), an individual must only spend down to the 209(b) income standard if they meet the SSI financial requirements (such as by receiving SSI, or a state supplement).[16] All persons who do not meet the SSI financial requirements must spend down to the state's MNIL.

States have considerable flexibility over whom to cover if they opt to have a medically needy program (Figure 5). All states that offer medically needy programs must cover pregnant women and children under age 18 who, except for income, would otherwise be eligible for Medicaid coverage.[17] States also have the option of covering four other groups of individuals: financially eligible children and young adults up to age 21; parents and caretaker relatives; elderly individuals (persons age 65 and older); and people with disabilities (including people who are blind).[18]

Of the 36 medically needy programs, only Texas does not provide medically needy coverage to the elderly and people with disabilities. Income and resource standards under the medically needy option must be the same for all covered groups, including low-income families, the elderly, and people with disabilities.

The following three examples illustrate the main ways that a person can qualify for Medicaid through the medically needy program:

1) **Recurring health expenses.** An elderly individual or a person with a disability has recurring medical expenses for services such as institutional care or prescriptions drugs, but has an income that is over the SSI income standard ($545/month of countable income for a single person, in 2002)[19]. Such individuals spend down on a continuing basis. For example, an adult with spinal cord injury who retired on disability receives monthly SSDI payments that make him ineligible for categorical coverage. He requires on-going physical and occupational therapy, as well as limited personal care services, home health services, and durable medical equipment. After meeting a spend-down requirement for a six-month period (in his state, the budget period for assessing medically needy coverage is six months), he qualifies for medically needy coverage for the remainder of the six-month period.

2) **An accident or catastrophic illness.** An individual who meets the criteria of a categorically needy Medicaid eligibility category, but exceeds the income standard, experiences an accident or catastrophic illness, causing the individual to spend-down on a one-time or short-term basis. For example, an eleven-year-old girl is injured in an automobile accident in which she dislocates her shoulder and suffers from internal injuries requiring surgery and follow-up medical care, along with short-term rehabilitation services. She lives in a family of four that is uninsured. The cost of the surgery, related medical expenses, and rehabilitation services cost nearly $40,000. Although her family income makes her ineligible for categorically needy Medicaid, after these medical expenses, her income is below the MNIL, making her eligible for medically needy coverage.

3) **Income below the MNIL, but above cash-assistance level.** A young adult or parent has no disabling health condition and has an income below the MNIL, but above the income standard for categorically needy eligibility. In this case, he or she is eligible without a spend-down requirement. Note: This option exists only in states where the MNIL is higher than the categorically needy income standards. For example, in Connecticut, the MNIL is the highest income standard for parent Medicaid coverage in the state. A father in a family of three earns $10,000 a year, below the MNIL of $10,392. Therefore, he qualifies for medically needy coverage without having to spend down. Additionally, states can cover "children" aged 19-20 through medically needy programs, even though categorically needy coverage for children only covers children through age 18.

Financial eligibility standards for the medically needy program vary considerably across states, but are typically well below poverty. State MNILs are low because they remain tied to AFDC levels that were in place in 1996. In 2001, the median MNIL for a single individual was $400, or 55% of the FPL (Figure 6 and Table 1). In 13 states offering medically needy coverage, the MNIL was below 50% of the FPL for non-institutionalized people with disabilities. In 26 states, the MNIL was below the SSI income level or 209(b) standard. Many states (15) have not raised their MNIL during the past decade.[20] Table 2 shows the wide variation in medically needy enrollment and spending across the states.

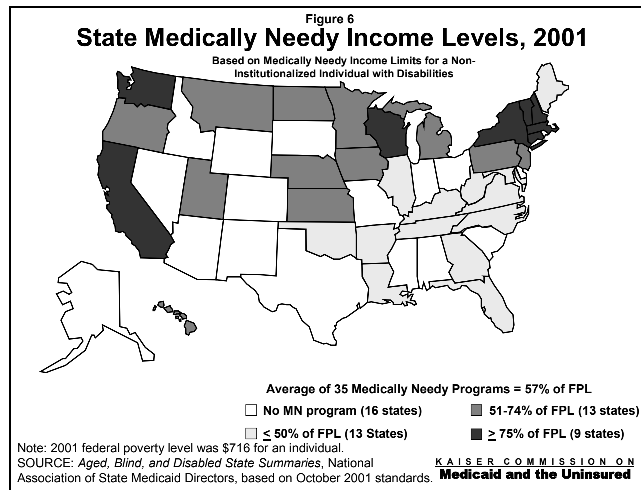


Table 1: Medically Needy Income Limits (MNIL) and Resource Standards, 2001

State	Individual			Couple			MNIL Last Changed
	MNIL in $	MNIL as % of FPL	Resource Limit	MNIL in $	MNIL as % of FPL	Resource Limit	
Median	**$400**	**55%**	**$2,000**	**$530**	**55%**	**$3,000**	**1994**
Alabama	---	---	---	---	---	---	---
Alaska	---	---	---	---	---	---	---
Arkansas	$108	15%	$2,000	$217	22%	$3,000	1988
Arizona	---	---	---	---	---	---	---
California	$600	83%	$2,000	$934	97%	$3,000	1989
Colorado	---	---	---	---	---	---	---
Connecticut*	$575/$476	80%/66%	$1,600	$734/$575	76%/59%	$2,400	1991
Delaware	---	---	---	---	---	---	---
District of Columbia	$377	53%	$2,600	$397	41%	$3,000	1994
Florida	$180	25%	$5,000	$241	25%	$6,000	1992
Georgia	$317	44%	$2,000	$375	39%	$4,000	1991
Hawaii*	$418	51%	$2,000	$565	51%	$3,000	1993
Idaho	---	---	---	---	---	---	---
Illinois*	$283	40%	$2,000	$375	39%	$3,000	1990
Indiana**	---	---	---	---	---	---	---
Iowa	$483	67%	$10,000	$483	50%	$10,000	1990
Kansas	$475	66%	$2,000	$475	49%	$3,000	1997
Kentucky	$217	30%	$2,000	$267	28%	$4,000	1989
Louisiana	$100	14%	$2,000	$192	20%	$3,000	1985
Maine	$315	44%	$2,000	$341	35%	$3,000	1991
Maryland	$350	49%	$2,500	$392	41%	$3,000	1994
Massachusetts[2]	No Limit	N/A	No Limit	No Limit	N/A	No Limit	1988
Michigan[3]	$408	57%	$2,000	$541	56%	$3,000	1992
Minnesota*	$482	67%	$3,000	$602	62%	$6,000	2001
Mississippi	---	---	---	---	---	---	---
Missouri*	---	---	---	---	---	---	---
Montana	$525	73%	$2,000	$525	54%	$3,000	2001
Nebraska	$392	55%	$4,000	$392	41%	$6,000	1988
Nevada	---	---	---	---	---	---	---
New Hampshire*	$544	76%	$2,500	$675	70%	$4,000	2001
New Jersey	$367	51%	$4,000	$434	45%	$6,000	Never
New Mexico	---	---	---	---	---	---	---
New York	$625	87%	$3,750	$900	93%	$5,400	2001
North Carolina	$242	34%	$2,000	$317	33%	$3,000	1990
North Dakota*	$475	66%	$3,000	$491	51%	$6,000	2001
Ohio**	---	---	---	---	---	---	---
Oklahoma*	$259	36%	$2,000	$325	34%	$3,000	2000
Oregon	$413	58%	$2,000	$526	54%	$3,000	1991
Pennsylvania	$425	59%	$2,400	$442	46%	$3,200	1990
Rhode Island	$625	87%	$4,000	$667	69%	$6,000	2001
South Carolina	---	---	---	---	---	---	---
South Dakota	---	---	---	---	---	---	---
Tennessee	$241	34%	$2,000	$258	27%	$3,000	1999
Texas[4]	---	---	---	---	---	---	--
Utah	$382	53%	$2,000	$468	48%	$3,000	1999
Vermont[5]	$791/$733	111%/102%	$2,000	$791/$733	82%/76%	$3,000	2001
Virginia*	$336	47%	$2,000	$406	42%	$3,000	2001
Washington	$557	78%	$2,000	$592	61%	$3,000	2001
West Virginia	$200	28%	$2,000	$275	28%	$3,000	1994
Wisconsin	$592	83%	$2,000	$592	61%	$3,000	1998
Wyoming	---	---	---	---	---	---	---

Source: *Aged, Blind, and Disabled State Summaries*, National Association of State Medicaid Directors, based on standards in effect on October 2001, (See www.nasmd.org/eligibility). **Notes:** 209(b) states are indicated with an asterisk (*). **Indiana and Ohio are 209(b) states that do not have MN programs, but the 209(b) statute requires them to allow individuals to spend-down to the cash assistance level. States marked with (---) do not have medically needy programs. In 2001, the FPL for an individual was $716/month in the contiguous US and $824 in Hawaii. For couples, the FPL was $968 in the contiguous US and $1,113 in Hawaii. [1] Connecticut has two income standards, based on the region. [2] Massachusetts does not have an income limit for non-institutionalized people with disabilities. For the elderly and people in institutions the income standard is 100% of FPL and the resource limit is $2,000 and $3,000 for individuals and couples, respectively. [3] Michigan has regional income standards. Standards in this table show the highest regional standards. [4] Texas operates a medically needy program, but it does not cover people with disabilities or the elderly. In 2001, the MNIL for a working parent with two children was $395 (32% of FPL). Source: *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000*, Center on Budget and Policy Priorities, February 2002. [5] Vermont uses a higher income standard for Chittenden County only.

Table 2: Medically Needy Enrollment and Spending, by State, 2000

State	Elderly		Disabled/Blind		Children		Adults		TOTAL	
	Enrollees	$ (thousands)	Enrollees	$ (thousands)	Enrollees	$ (thousands)	Enrollees	$ (thousands)	Enrollees	$ (thousands)
TOTAL	663,183	10,873,693	524,158	9,058,868	1,440,273	1,987,388	944,143	1,832,332	3,571,757	23,752,281
AL	---	---	---	---	---	---	---	---	---	---
AK	---	---	---	---	---	---	---	---	---	---
AR	371	1,122	2,888	19,842	13,667	20,337	9,286	16,399	26,212	57,700
AZ	---	---	---	---	---	---	---	---	---	---
CA	176,993	1,900,915	96,419	1,370,795	506,186	481,029	172,642	233,303	952,240	3,986,042
CO	---	---	---	---	---	---	---	---	---	---
CT	12,271	132,657	21,558	201,342	3,592	5,649	2,702	5,155	40,123	344,803
DE	---	---	---	---	---	---	---	---	---	---
DC	3,747	119,318	3,755	85,118	11,482	17,994	6,913	23,291	25,897	245,721
FL	20	16	16,986	102,999	13,651	16,374	38,875	50,176	69,532	169,565
GA	4,280	26,159	5,490	33,190	97	115	7	7	9,874	59,471
HI*	1,991	47,321	544	5,389	6	1	8	1	2,549	52,712
ID	---	---	---	---	---	---	---	---	---	---
IL	72,728	1,035,742	113,478	1,849,770	3,416	3,885	179,031	326,681	368,653	3,216,078
IN	---	---	---	---	---	---	---	---	---	---
IA	3,110	8,065	2,880	20,947	820	1,212	2,937	7,651	9,747	37,875
KS	6,950	24,515	5,367	35,877	566	3,066	306	253	13,189	63,711
KY	2,816	29,050	2,778	21,669	25,582	38,851	19,237	42,575	50,413	132,145
LA	1,472	9,751	2,083	15,215	678	392	3,964	10,116	8,197	35,474
ME	820	7,502	449	8,650	117	573	65	162	1,451	16,887
MD	23,323	556,062	19,633	316,598	25,180	95,124	15,702	50,646	83,838	1,018,430
MA	10,502	90,505	11,404	123,655	0	0	0	0	21,906	214,160
MI	6,353	54,327	8,777	47,281	49,841	42,944	58,226	86,675	123,197	231,227
MN	4,353	19,130	5,454	68,891	481	871	39	77	10,327	88,969
MS	---	---	---	---	---	---	---	---	---	---
MO	---	---	---	---	---	---	---	---	---	---
MT	5,927	84,955	2,544	32,981	80	205	15	2	8,566	118,143
NE	10,536	229,562	2,307	82,947	10,399	12,765	15,384	24,889	38,626	350,163
NV	---	---	---	---	---	---	---	---	---	---
NH	4,756	83,554	2,920	41,173	1,484	3,265	2,335	5,307	11,495	133,299
NJ	3,650	65,643	1,125	10,426	370	262	0	0	5,145	76,331
NM	---	---	---	---	---	---	---	---	---	---
NY	209,103	5,116,748	139,572	4,031,573	642,268	1,082,944	245,553	630,515	1,236,496	10,861,780
NC	19,897	345,041	7,631	136,793	3,242	4,426	8,909	27,948	39,679	514,208
ND	6,582	120,899	2,950	68,974	5,166	5,992	2,486	3,284	17,184	199,149
OH	---	---	---	---	---	---	---	---	---	---
OK	840	540	2,288	5,506	1,882	753	4,047	4,517	9,057	11,316
OR	1,967	4,815	5,269	29,779					7,236	34,594
PA	33,470	512,556	5,860	54,795	39,292	48,098	52,383	59,733	131,005	675,182
RI	3,829	82,298	960	18,227	10	9	98	183	4,897	100,717
SC	---	---	---	---	---	---	---	---	---	---
SD	---	---	---	---	---	---	---	---	---	---
TN	7,490	2,172	5,299	12,149	52,087	69,611	45,790	85,416	110,666	169,348
TX	0	0	0	0	2,417	3,841	47,867	119,345	50,284	123,186
UT	870	5,781	1,582	11,376	2,008	1,218	2,186	4,434	6,646	22,809
VT	3,234	11,085	3,077	17,014	2,982	5,472	2,953	4,753	12,246	38,324
VA	4,981	41,596	4,653	53,151	442	3,537	101	257	10,177	98,541
WA	5,648	47,900	7,655	55,347	62	110	56	65	13,421	103,422
WV	545	2,007	2,732	19,649	53	157	1,399	4,506	4,729	26,319
WI	7,758	54,385	5,791	49,784	20,667	16,306	2,641	4,012	36,857	124,487
WY	---	---	---	---	---	---	---	---	---	---

Source: Centers for Medicare and Medicaid Services, Medicaid Statistical Information System (MSIS) Data Reports, 2000.
Note: States marked with (---) do not have medically needy programs. * Hawaii data are for 1999, the state has not reported 2000 data.

How the Medically Needy Program Works for the Elderly and Persons with Disabilities

For people in institutions, the medically needy program is particularly important because nursing home care is expensive and many people do not have sufficient income or assets to pay for this care. For elderly and persons with disabilities living in the community, Medicaid coverage is often the only way they are able to pay for personal attendant care, prescription drugs, or other medical services. While Medicare assists the elderly and some people with disabilities, it leaves many expenses uncovered, including prescription drugs and long-term institutional or community-based care. Medicaid also plays an important role in assisting some low-income Medicare beneficiaries by paying Medicare premiums and cost-sharing obligations.

The SSI level for an individual was $545/month in 2002, or 74% of the FPL.[21] While the SSI program generally provides a floor of eligibility for cash assistance, many elderly and persons with disabilities who face high or recurrent medical or long-term care expenses receive income from Social Security or private pensions that exceed these SSI limits.[22] For example, people with disabilities who receive SSDI, which is based on past work history and earnings, frequently exceed the SSI income standard.[23] In 2000, the average monthly SSDI benefit was $786/month, considerably higher than the SSI income standard of $512/month in that same year.[24,25] The average SSDI beneficiary has too much income to qualify for SSI and related categorically needy Medicaid coverage. Medically needy coverage provides states with an option to provide Medicaid assistance to elderly and persons with disabilities who are ineligible for SSI because of income. For these individuals, the medically needy pathway may be the only way they can qualify for Medicaid.

A 50-year-old Washington, DC resident with multiple sclerosis who has retired on disability has monthly prescription drug costs of roughly $500 and physician services costs that average $250/month. This individual receives a monthly SSDI payment of $800, but has no other income. After disregarding certain income, his countable income is $745/month. Although DC has expanded categorically needy eligibility for the elderly and disabled up to 100% of poverty, his income remains above the income standard of $738/month. His only Medicaid eligibility option is medically needy coverage. The MNIL in DC is $377; therefore, to become eligible for medically needy coverage he must spend down at least $368 per month. His average monthly expenses of $750 easily meet this spend-down requirement.

$745 (countable income) - $377 (MNIL) = $368 (spend-down requirement)

In the 35 states, including D.C., with a medically needy program for the elderly and persons with a disabilities, institutionalized individuals whose income exceeds the state's MNIL or categorically needy must spend-down to the state's MNIL to qualify for Medicaid. Depending on the state, the income limit for institutionalized individuals could be either the SSI-related income standard or a higher income eligibility level permitted under the "300 percent rule."[26]

Once an institutionalized individual has established eligibility under the medically needy program, all of the income that the individual receives is applied to the cost of the institutional care, with the exception of a small "personal needs allowance," typically $50 or less per month. Individuals are also required to meet the resource requirements,

typically those used in the SSI program. Twenty-five states have a medically needy program for the elderly and persons with disabilities and also use the “300 percent rule” to establish eligibility for persons who are institutionalized (Table 3). Regardless of which pathway through which an institutionalized individual enters the Medicaid program, virtually all income and resources must be put toward the cost of care.

Sixteen states do not have a medically needy program. In 14 of these states, individuals in institutions can be covered under the “300 percent rule”, which provides relief to some higher-income persons in need of institutional services. Even though individuals in these states may qualify for Medicaid under a higher income level, they are still required to apply all of their income, with the exception of the personal needs allowance, toward the cost of care. For individuals with a spouse or family member living at home, Medicaid also provides for a family or spousal maintenance allowance, so that a certain amount of income is excluded, enabling the remaining family member to continue to live in the community without hardship.[27]

Two states, Indiana and Ohio, do not have a medically needy program or use the “300 percent rule” for individuals who are institutionalized. Because both states are 209(b) states, they are required to permit individuals receiving SSI or a state supplement to spend down to the cash assistance income limit. For individuals, this is $545/month or 74% of poverty and $460/month or 62% of poverty for Indiana and Ohio, respectively in 2002.

An 85-year-old Kansas resident with Alzheimer’s disease requires nursing home care. Kansas uses the 300 percent rule for institutionalized individuals (in 2002, $1,635/month). This woman, a retired school administrator, has a pension and other monthly income totaling $2,400. After income disregards, her countable income is $2,260/month. She has no surviving spouse. Because she exceeds the “300 percent rule”, her only option for Medicaid is medically needy coverage. She is allowed to keep $30/month for personal needs, and the remainder of her income goes to the nursing home to cover her extensive medical and support needs.

Table 3: Medicaid Eligibility Standards for Institutionalized Individuals, 2001

State	Medically Needy Program (%FPL)	300 Percent Rule (%of SSI)	Personal Needs Allowance
Median	**55%**	**300%**	**$40**
Alabama	---	300%	$30
Alaska	---	300%	$75
Arkansas	15%	300%	$40
Arizona	---	300%	$76.65
California	83%	---	$35
Colorado	---	300%	$50
Connecticut*	80%-66%	---	$54
Delaware	---	250%	$44
District of Columbia	53%	---	$70
Florida	25%	300%	$35
Georgia	44%	300%	$30
Hawaii*	51%	---	$30
Idaho	---	300%	$40
Illinois*	40%	---	$30
Indiana**	---	---	$50
Iowa	67%	300%	$30
Kansas	66%	300%	$30
Kentucky	30%	300%	$40
Louisiana	14%	300%	$38
Maine	44%	300%	$40
Maryland	49%	300%	$40
Massachusetts	100%	---	$60-65
Michigan	57%	300%	$60
Minnesota*	67%	300%	$69
Mississippi	---	300%	$44
Missouri*	---	180%	$30
Montana	73%	---	$40
Nebraska	55%	---	$50
Nevada	---	300%	$35
New Hampshire*	76%	236%	$50
New Jersey	51%	300%	$40
New Mexico	---	300%	$47
New York	87%	---	$50
North Carolina	34%	---	$30
North Dakota*	66%	---	$40
Ohio**	---	---	$40
Oklahoma*	36%	300%	$50
Oregon	58%	300%	$30
Pennsylvania	59%	300%	$30
Rhode Island	87%	300%	$50
South Carolina	---	300%	$30
South Dakota	---	300%	$30
Tennessee	34%	300%	$30
Texas	---	300%	$60
Utah	53%	300%	$45
Vermont	102%	270%	$47.66
Virginia*	47%	300%	$30
Washington	78%	300%	$41.62
West Virginia	28%	300%	$50
Wisconsin	83%	300%	$45
Wyoming	---	300%	$50

Source: *Aged, Blind, and Disabled State Summaries*, National Association of State Medicaid Directors, based on standards in effect on October 2001, (See www.nasmd.org/eligibility).
Notes: In 2001, the FPL for an individual was $716/month in the contiguous United States and $824 in Hawaii. 209(b) states are indicated with an asterisk (*). **Indiana and Ohio are 209(b) states that do not have MN programs, but the 209(b) statute requires them to allow individuals to spend down to the cash assistance level. The income standard for a person with disabilities is 74% of FPL in Indiana and 62% of FPL in Ohio. States marked with (---) do not have a MN program. Connecticut has two income standards, based on the region. Michigan has regional income standards. The standard shown here represents the highest regional standards. Texas's MN program does not cover the elderly and individuals with disabilities.

How the Medically Needy Program Works for Children and Parents

For low-income children and parents who are not disabled, the medically needy program provides a pathway to Medicaid for those who exceed categorically needy income eligibility levels, but still have low incomes. Federal rules require that states provide Medicaid to children under age 6 up to 133% of the FPL and for those ages 6 to 18 up to100% of the FPL. Some states have expanded eligibility for children and parents above the minimum levels; however, in many states, eligibility levels for parents remain very low. Families can qualify for medically needy coverage by having income below the state's MNIL or by incurring out-of-pocket health expenses that would reduce their income and resources below the applicable MNIL. Individuals who qualify for categorically needy coverage must be covered under that pathway, rather than through the medically needy option.

In fifteen states, the MNIL is higher than the state's eligibility level for categorical parent coverage.[28] Therefore, a parent could meet this standard without spend-down. Nevertheless, medically needy parents still have very low incomes. Across all medically needy programs, the median MNIL for parents is 53% of the poverty level ($663/month for a family of three in 2000), and only one state (Minnesota) has an MNIL equal to 100% of the poverty level ($1,252/month for a family of three in 2000). The lowest MNIL for parents is in Louisiana, where it is 26% of the poverty level ($325/month for a family of three in 2000).[29] Many medically needy children and parents are relatively healthy and may not have recurring health care expenses, but may not be able to obtain or afford private health insurance coverage.

A single mother of twin boys, age 6, lives in Texas. She is in a job-training program, and she works 10 hours per week providing after school day care for a 9-year-old girl. Her total monthly income is $500. After income disregards, her income is $350—less than 30% of the FPL. Because of her family's low income, her sons qualify for Medicaid as categorically needy. Since her income is below $395, the MNIL for a family of 3 in Texas, she qualifies for Medicaid as medically needy, without having to spend-down.

A family in Pennsylvania has a daughter, age 5. Both parents work in the hospitality industry making $7/hour. The father works full-time and the mother works part-time, spending the remaining time caring for her child. Neither parent receives health insurance benefits. The family's total monthly income is $1,820 and the countable income after income disregards is $1,550. This is below 133% of poverty level for a family of three of $1,622/month—the state's income standard for children under age 6. Therefore, the daughter qualifies for Medicaid. Because the family income exceeds both the categorically and medically needy income standard for parent coverage (for a family of three, the maximum monthly income for categorically needy is $806 and for medically needy is $442), neither parent is eligible for coverage.

One day in January, after a bad ice storm, the mother is carrying groceries into the house and she slips and falls on the ice breaking her arm. Because it was a bad break, she ends up in the hospital in traction for two weeks, before even getting a cast. Her hospital bill and related expenses was $14,000. She is able to get medically needy coverage through spend-down. Since the MNIL is $442, her spend-down obligation is $1,108/month. Because the state uses a 6-month budget period, she must spend-down $6,648 before receiving Medicaid coverage.

$1,550 (countable income) - $442 (MNIL) = $1,108/month (monthly spend-down)

$1,108/month (monthly spend-down) x 6 months (budget period) = $6,648 (what she must incur every six months before getting Medicaid coverage)

Mandatory categorically needy coverage of poor children under age 19 became effective on September 30, 2002.[30] However, in many states, medically needy coverage is still the only option for states to cover young adults between ages 19-20, since these young adults (without children) cannot qualify as categorically needy, regardless of their income. For example, California's medically needy program covers low-income children under age 21 in families who are not categorically eligible. Approximately 252,000 children—or 5% of the state's total Medicaid enrollment—qualify in this manner.[31]

A 20-year-old single male in California works at a part-time job where he earns $6.75/hour (the minimum wage in California). His monthly income is $585. The MNIL for a single person in California is $600. Therefore, he qualifies for Medi-Cal as medically needy without a spend-down requirement.

WHAT BENEFITS ARE COVERED BY MEDICALLY NEEDY PROGRAMS

States can provide a more limited benefit package to medically needy beneficiaries than for categorically needy beneficiaries. Most notably, states may exclude coverage of institutional services and some optional services, such as eyeglasses or dental care, from their medically needy coverage. States are also permitted to place different limitations on covered services for the medically needy and charge higher cost-sharing for medically needy beneficiaries.[32]

Federal requirements for medically needy programs require states to:[33, 34, 35]

1. Provide ambulatory services to children under 18 and individuals entitled to institutional services.
2. Provide prenatal care and delivery services to medically needy pregnant women.
3. If a state provides medically needy coverage for services in Institutions for Mental Disease or Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) (or both), then it must provide to all medically needy beneficiaries either all required services for the categorically needy (except nurse practitioner services) or the following services: inpatient hospital services, outpatient hospital services, laboratory and x-ray services, nursing facility services, physician services, and nurse-midwife services.

Most states provide the same benefits package to the medically needy that they provide to categorically needy beneficiaries, despite flexibility to provide fewer services. For example, an analysis of Medicaid covered services for children found that 28 of the 36 medically needy programs cover a benefit package similar to that provided to categorically needy beneficiaries.[36] All medically needy programs provide coverage for inpatient hospital, outpatient mental health, pharmacy, and emergency transportation services. Of the eight states that do not provide medically needy and categorically needy children the same package of benefits, most only exclude a few selected services, such as ICF/MR services, hospice services, home health services and medical supply services. Additionally, six states (Florida, Iowa, Louisiana, Oregon, Virginia, and Washington) do not cover at least some long-term care services for the medically needy.[37]

POLICY ISSUES and CONCLUSIONS

Medically needy programs provide states an opportunity to expand Medicaid eligibility to individuals with high medical expenses who would otherwise qualify for coverage, but exceed categorically needy income limits. While many beneficiaries depend on this option and states appreciate their ability to obtain federal matching payments through these programs, several policy issues emerge:

Medically needy programs are at risk in states experiencing fiscal downturns.

At the current time, most states are experiencing significant or severe budget pressures in their Medicaid programs. Based on estimated spending through May 2002, Medicaid expenditures are increasing 13.3% in FY 2002. This follows a 10.6% increase in FY 2001. By contrast, Medicaid revenues grew roughly 5% over the fiscal 2000-2002 period. A recent survey report indicated that 49 states were cutting back their Medicaid programs in FY2003 year.[38]

While states have been considering numerous Medicaid cost-containment options, a number are considering or have adopted reductions in eligibility and benefits for existing Medicaid beneficiaries. For FY 2003, 27 states plan to take action to reduce or restrict Medicaid eligibility, and several states have proposed cutting or eliminating their medically needy programs. Last year, Florida reduced the eligibility level for the elderly and persons with disabilities from 90% of FPL to 88% of FPL. Florida also cut its medically needy program, but restored it a few months later. Florida's medically needy program will have to be reauthorized in the spring of 2003. Oklahoma proposed eliminating its medically needy program effective November 1, 2002, but delayed action until March 2003. In March 2003, Michigan will no longer cover caretaker relatives.

Many elderly individuals qualify through the medically needy pathway to obtain assistance with nursing facility costs or for prescription drug expenses that are not covered by Medicare. Reducing medically needy coverage could result in greater financial burden on these individuals, in these individuals going without necessary medicines, and in providers absorbing added costs. Reducing medically needy coverage could also limit access to providers because providers may refuse to accept patients that are not eligible for Medicaid, out of concern that they could not be guaranteed payment. This could be especially problematic for people with disabilities who often rely on specialist providers. In many communities, a very small number of providers are responsible for providing the majority of care to people with specific types of disability—loss of even one provider willing to accept patients could seriously jeopardize access to appropriate care.

Restricting or eliminating medically needy programs could also have a ripple effect throughout the health care system. When indigent individuals receive care in hospital emergency rooms, hospitals reasonably attempt to minimize their uncompensated care burden. One of the major tools available to hospitals is to establish Medicaid eligibility for these individuals through the medically needy option. If states eliminate these

programs, the result may be that hospitals are forced to absorb significantly higher uncompensated care costs. Similarly, as previously highlighted, medically needy coverage fulfills a significant role for many individuals in nursing homes. If states restrict or eliminate medically needy programs, it could mean the loss of a primary revenue stream for nursing homes and other institutional providers.

States generally have not updated medically needy income standards on a regular basis.

In 15 states, the MNIL has not been adjusted in 10 years or more.[39] This means that the income standard, as a percentage of the poverty level, has decreased substantially over time. In some states, the MNIL is so low that individuals are unable to finance non-health related necessities such as food and housing because such a large portion of their income must go toward the spend-down requirement. This is especially problematic for persons with specific types of service needs, such as individuals seeking non-institutional residential living arrangements in assisted living centers. A barrier to Medicaid can be created if an individual does not have the financial resources to meet their spend-down obligation upfront for a spend-down obligation calculated over a budget period of several months. Assisted living centers and other smaller entities may not be willing to provide services before they are certain that the individual has become eligible for Medicaid.[40]

In states without medically needy programs—a person with ongoing high-cost health conditions can not spend-down to eligibility.

Medically needy income levels (MNILs) vary greatly across the states. Twenty-six states use MNILs below SSI standards (74% of FPL for an individual). While the MNIL is very low in some states, having this option provides an important safety-net for persons with high recurring health care expenses. Twelve states, however, do not operate medically needy programs or provide a 209(b) spend-down opportunity, leaving residents with no option to spend down to Medicaid eligibility no matter how high their medical expenses are in relation to their income. The variation in medically needy eligibility among the states means that an individual who has the same income as an individual in a state with a medically needy program would not be able to get needed services.

Medically needy eligibility processes are complex and can be burdensome on states and beneficiaries.

For many categorically needy Medicaid beneficiary groups, eligibility generally is redetermined annually.[41] Medically needy programs, however, require a much more burdensome ongoing re-determination process for those beneficiaries who must spend-down to become eligible for coverage. First, eligibility is assessed for a budget period of one to six months. During this time, states must collect and review receipts of incurred expenses and pay claims only after the spend-down has been met. The process of accounting for incurred expenses adds an additional layer of financial management that

does not exist for other eligibility groups. Moreover, this process begins anew each budget period.

States have several opportunities, however, to minimize the administrative burdens of a medically needy program. For example, new federal regulations became effective in May 2001 that give states broader flexibility in using less restrictive income methodologies for determining Medicaid eligibility. These regulations, commonly referred to as the "1902(r)(2) regulations", give the state the option of disregarding more income when determining eligibility. For example, a state could elect to disregard a certain type of income (such as SSDI payments). A state could also disregard income used for a specific purpose, such as income used to maintain a home. If a state takes advantage of this flexibility, the effect could be that more individuals would gain Medicaid eligibility as categorically needy. It could also mean that individuals who must spend down to gain medically needy eligibility would have to incur fewer expenses before they gain eligibility for Medicaid. Prior to the issuance of new regulations, most of the states that took advantage of the 1902(r)(2) flexibility applied less restrictive income methodologies only for children.[42]

For non-institutionalized beneficiaries, the spend-down requirement can be burdensome. Beneficiaries must obtain and submit receipts for all incurred expenses, and they must arrange for services to be provided before they meet the spend-down requirement. This is especially difficult in states that have a long budget period. For example, if an individual has a $400 monthly spend-down obligation, but they reside in a state with a six-month budget period, they must incur $2,400 of expenses before their Medicaid coverage begins.

Medically needy coverage can also be less stable and reliable, especially for individuals who do not have recurring high-cost expenditures every month. Presumably, a large number of individuals cycle in an out of medically needy eligibility, depending on whether or not their expenses are sufficient to meet the spend-down obligation for a specific budget period.

Better information is needed on the characteristics and needs of medically needy beneficiaries and how these programs operate to identify best practices.

While states report a broad range of information about categorically needy groups to the Centers for Medicare and Medicaid Services (CMS), far less information is reported about the characteristics of medically needy populations. Little data are available to evaluate how well Medicaid is meeting their health care needs. By definition, we know that, initially, the income of medically needy beneficiaries is above the income of categorically needy groups. We also know that after they meet the spend-down requirement, medically needy beneficiaries often have lower remaining income with which to meet non-health related living expenses. We do not have a full picture of what level of income medically needy beneficiaries have, how much over the categorical income standards most beneficiaries are, and how they provide for food, shelter, and other costs in states where the MNIL is a very low percentage of the FPL. Medically

needy beneficiaries cost more—and use more services than other groups. Beyond this, however, limited data are available to understand what their health care needs are and how they differ from the needs of categorically needy beneficiaries. Further, too little is known about the management of these programs to identify strategies for minimizing the administrative burden on states that operate them.

In sum, medically needy programs provide an important "last chance" for Medicaid coverage for persons who have too much income to qualify as categorically needy. This option is especially important for the elderly and people with disabilities who may face large health expenses, but exceed the income standard for categorically needy eligibility categories. It is also important for children and their parents with incomes above the categorically needy levels.

More data are needed to understand these programs and to ensure that beneficiaries are well served by them. Before any precipitous changes are made to state medically needy programs, policymakers and others must have a better understanding of who is served by medically needy programs, what their specific health care needs are, and how effectively existing medically needy programs are serving their needs.

Appendix 1

HOW TO CALCULATE SPEND-DOWN

Individuals who have incomes above the state's MNIL, but who fall below that level once their medical expenses are deducted can become medically needy through spend-down. To spend down, an individual must incur (but not necessarily pay) medical and remedial care expenses that bring their countable income below the MNIL.

Several factors affect the determination of Medicaid eligibility through spend-down, including:

- Income eligibility
- Resource eligibility
- Budget period
- Pay-in spend-down

Income Eligibility

There are two components to determining income eligibility, the income standard and the income methodology. The standard is the maximum amount of countable monthly income an individual can have and still be eligible for Medicaid. The methodology is used to determine how much of a person's income is counted toward the income standard.

In most circumstances, federal regulations require a state to use a single income standard for all medically needy beneficiaries. Although a state can establish a single MNIL for mandatory and optional groups, it must establish a single MNIL for all mandatory groups and for all optional groups.[43] For example, a state must use the same MNIL for children and elderly individuals who qualify for Medicaid through a mandatory eligibility pathway, but can use a different MNIL for a child or elderly individual who qualifies for Medicaid through an optional eligibility pathway. States have broad discretion in setting the income standard, although they can only receive federal matching payments for individuals whose income is below a maximum of 133% of the state's 1996 AFDC payment level. States can adjust this level for inflation, but adjustments cannot exceed increases in the consumer price index.[44] The MNIL can also vary between urban and rural areas based on differences in housing costs.[45] States are permitted, but not required, to increase the MNIL as family size increases, but they are prohibited from decreasing MNIL as family size increases. In most states, the income standard must be set at an amount no lower than the lowest income standard used to determine eligibility under the related cash assistance programs.[46] The 209(b) states are allowed an exception to establish a more restrictive income standard for medically needy blind and disabled individuals than for medically needy families with children.[47]

States have flexibility in establishing income methodology, and the rules that each state chooses to apply can vary dramatically. Elements of the methodology include: definitions of income, exclusions or disregards of income, composition and number of persons included in the budgetary unit, deeming of income from spouses and parents, treatment of regular and periodic income, and ownership of income. Except for 209(b) states, the methodology that a state uses to count income can be no more restrictive than those that are used in the most closely related cash assistance program.[48] Therefore, a state may have a single income standard for all groups, but use a different methodology for determining whether income falls below the standard for children, parents, people with disabilities, and the elderly.

Resource Eligibility

For most eligibility categories, individuals must have resources (such as cash or possessions) of less than a specified amount to qualify for Medicaid. The resource standard refers to the maximum amount of countable assets an individual can possess and still maintain Medicaid eligibility. As with the income standard, federal regulations require, in most circumstances, that states use a single resource standard for all medically needy beneficiaries. Although the resource standard can vary between mandatory and optional groups, it must be uniform within mandatory and optional groupings.[49] In the non-209(b) states, the resource standard must be equal to the highest standard used to determine eligibility in the most closely related cash assistance program.[50] As with the income standard, 209(b) states are permitted to establish a more restrictive resource standard for medically needy aged, blind, and disabled individuals than for medically needy families with children.[51]

Federal rules for the resource methodology mirror those for the income methodology. Typically, the value of a home (if it is the primary residence) is excluded, no matter the value. Also, the value of a car is often excluded when it is necessary for transportation to receive medical care.[52]

Budget Period

In determining eligibility, the state selects a budget period of between one and six months, during which time an applicant will be assessed to determine whether they meet their spend-down obligation. Depending on an individual's circumstance, and whether or not his or her medical expenses are incurred on an ongoing basis, the length of the budget period can make it easier or harder for an individual to meet the spend-down requirement.

States are permitted to use more than one budget period. For example, the state could establish one budget period for institutionalized individuals and another for non-institutionalized individuals. Further, the state could establish two budget periods for non-institutionalized individuals. In this case, however, the state must allow the applicant to select which budget period will be applied.[53]

The length of the budget period can pose a significant barrier to Medicaid coverage for people in certain circumstances, including persons in need of home and community based services or persons desiring to live in an assisted living center.[54] This is because the full spend-down for the length of the budget period must be incurred before Medicaid coverage begins. In this case, either the individual needs to pay the full spend-down with his or her own funds or the provider must be willing to wait for payment until Medicaid coverage begins. Institutional providers and larger providers may be more willing to begin caring for an individual before they are determined to be eligible for Medicaid, something that smaller, community based providers are unable to do.

There are advantages to both a short and a long budget period. Presumably, a long budget period is administratively preferable. However, for many beneficiaries, a shorter budget period makes it easier to qualify for Medicaid because they only need to meet the spend-down requirement one month at a time.[55] For some individuals, however, a longer budget period may be preferable if they have recurring high-cost health conditions. In this case, they may prefer to meet their spend-down and then have a longer period of Medicaid coverage before having to spend down once again.

Pay-In Spend-down

States can also permit provide an alternative method for individuals to meet the spend-down requirement, called Pay-in Spend-down. This involves individuals making a cash payment to the state to satisfy the spend-down requirement. For example, if an individual has a spend-down obligation of $500, which is partially satisfied through incurring $300 of medical expenses, the state can accept a cash lump sum or installment payment of $200 for the balance. It can be beneficial to allow individuals to use a pay-in spend-down. For example, if an individual pays in, then they can be eligible for Medicaid before any medical expenses are incurred. This would mean that all expenses are billable at Medicaid payment rates. If an individual must incur expenses before they are eligible, then the services would not be billed at Medicaid rates or they would not be eligible for discounts and rebates negotiated by Medicaid.

[1] Centers for Medicare and Medicaid Services, 2000 Medicaid Statistical Information System (MSIS).
[2] Centers for Medicare and Medicaid Services, 2000 Medicaid Statistical Information System (MSIS): National Totals.
[3] *Medicaid: A Primer*, Kaiser Commission on Medicaid and the Uninsured, September 1999.
[4] *Medicaid "Mandatory" and "Optional" Eligibility and Benefits*, Kaiser Commission on Medicaid and the Uninsured, July 2001.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Because mandatory categorical eligibility for children under 18 covers children in families up to the poverty level, children under age 18 in medically needy programs qualify only if they are in higher income families and spend down. While children who spend down would be expected to have higher per capita costs than other children, the costliest medically needy children would be expected to fall into the disabled category. The medically needy children category also covers young adults aged 19-20. In the absence of a waiver, medically needy programs are the only way for states to cover these young adults. Since these individuals are relatively healthy, they lower the per capita cost for the medically needy children group. California covers young adults up to age 21 and its medically needy enrollment for children accounts for 35% of all medically needy children, nationally. California's per capita cost for medically needy children is $950, compared to $1,380 for all medically needy children nationally. Source: Centers for Medicare and Medicaid Services, 2000 MSIS: California Tables.
[9] *Aged, Blind and Disabled State Summaries*, National Association of State Medicaid Directors, based on standards in effect on October 2001. http://medicaid.aphsa.org/research/abd/abd/htm.
[10] 42 CFR § 435.1007. This regulation includes a couple of exceptions: 1) California is permitted to base the AFDC income limitation using the AFDC income limit for a three person household with one adult and two children when calculating the maximum income standard for a 2-person household as long as one person is aged, blind or disabled; and 2) A state, that as of June 1, 1989 had in its state plan an amount for individuals that was "reasonably related" to 133-1/3% of the highest amount of AFDC which would ordinarily be paid to a family of two without income or resources may use an amount based on a "reasonable relationship" to such an AFDC standard for a family of two.
[11] *State Medicaid Manual,* § 3621.
[12] *State Medicaid Manual,* § 3621.
[13] The Medicaid Resource Book, The Kaiser Commission on Medicaid and the Uninsured, July 2002.
[14] *The Green Book*, House Ways and Means Committee, October 2000 (See p. 897).
[15] Ibid.
[16] *State Medicaid Manual,* § 3613.3 (A). Individuals are also considered to be meet the financial requirements for SSI if they would be eligible for SSI or a state supplement with Old Age and Survivors Disability Insurance (OASDI) cost-of-living disregards applied under 42 CFR 214.134 and 435.135.
[17] § 1902(a)(10)(C)(ii) of the Social Security Act and *State Medicaid Manual*, § 3611.
[18] *State Medicaid Manual*, § 3612.
[19] *SSI Monthly Payment Amounts*, Social Security Administration, 2002.
[20] Excludes Illinois whose MNIL was updated in 2002.
[21] http://www.ssa.gov/OACT/COLA/SSIamts.html and http://aspe.hhs.gov/poverty/02poverty.htm
[22] SSI is a federal income support program for low-income people with disabilities. To receive SSI, an individual must meet the Social Security Administration's disability standard and their income must fall below a maximum income level. Except in the 209(b) states, the income level is 74% of the federal poverty level for a single, non-institutionalized adult. In 2002, the monthly SSI income standard is $545. The monthly 2002 federal poverty level in the 48 contiguous United States is $738.33. Social Security Administration.
[23] SSDI provides income support payments to people with disabilities who have a sufficient work history (wherein they contributed to the Social Security system) or to widows, widowers, or disabled children of workers based on the primary beneficiary's work history. *Social Security Disability Frequently Asked Questions*, National Organization of Social Security Claimant's Representatives, see http://www.nosscr.org/hallfaq.html#02.
[24] *Annual Statistical Report on the Social Security Disability Insurance Program, 2000*, Social Security Administration, Office of Policy, see http://www.ssa.gov/statistics/di_asr/2000/index.html
[25] *2001 SSI Annual Report*, Social Security Administration, see Table IV.A2, http://www.ssa.gov/OACT/SSIR/SSI01/EcoDemoAssumptions.html#25519.

[26] The special income rule known as the "300 percent rule" enables states to set an income standard up to 300% of the SSI income benefit ($1,635/month in 2002) for institutionalized populations (residing in a hospital, nursing facility, or an intermediate care facility for persons with mental retardation (ICF/MR). Sources: *The Green Book*, House Ways and Means Committee, October 2000 (See p. 900) and *2002 SSI FBR, Resource Limits, 300% CAP, Break-Even Points, Spousal Impoverishment Standards*, Centers for Medicare and Medicaid Services.
[27] *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, July 2002.
[28] In 13 states, the medically needy income standard for a parent with two children is the highest income standard. These states are: Arkansas, Connecticut, Illinois, Louisiana, Maryland, Michigan, Nebraska, New Hampshire, New York, Pennsylvania, Texas, Virginia, and West Virginia. In two states (Florida and Utah), the medically needy income standard and the 1931 income standard are jointly the highest income standard for a parent with two children. Source: Matthew Broadus, Shannon Blaney, Annie Dude, Jocelyn Guyer, Leighton Ku, and Jaia Peterson, *Expanding Family Coverage: State's Medicaid Eligibility Policies for Working Families in the Year 2000*, Center on Budget and Policy Priorities, February 2002, (See Table 2).
[29] Ibid, see Table 13.
[30] Ibid. All states are required to cover children up to 100% of the poverty level under age 19 as of September 2002.
[31] *Medi-Cal Facts: Share of Cost Medi-Cal*, Medi-Cal Policy Institute, 2001.
[32] *An Advocate's Guide to the Medicaid Program*, p. 4.8.
[33] § 1902(a)(10)(C)(iii) of the Social Security Act.
[34] § 1902(a)(10)(C)(iv) of the Social Security Act.
[35] *An Advocate's Guide to the Medicaid Program*, p. 4.4.
[36] *Medically Needy Covered Services for Children (as of June 2000)*, National Academy for State Health Policy, April 2001.
[37] http://medicaid.aphsa.org/research/ABD/
[38] Vernon Smith, Kathy Gifford, Rekha Ramesh, and Victoria Wachino, *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003,* The Kaiser Commission on Medicaid and the Uninsured, January 2003.
[39] *Aged, Blind, and Disabled State Summaries*, National Association of State Medicaid Directors, January 2002, (See http://medicaid.aphsa.org/research/ABD/abd.htm.)
[40] Robert L. Mollica and Robert Jenkens, *State Assisted Living Practices and Options: A Guide for State Policy Makers*, National Academy for State Health Policy and NCB Development Corporation, September 2001.
[41] Ibid, p. 2.12 and 42 C.F.R. § 435.916(a).
[42] Health Care Financing Administration, *Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers*, May 2001.
[43] Centers for Medicare and Medicaid Services, *State Medicaid Manual*, Chapter VII, § 3621, Rev. 67.
[44] 42 U.S.C. § 1396u-1(f)(3).
[45] *State Medicaid Manual*, Chapter VII, § 3621.
[46] *An Advocate's Guide to the Medicaid Program*, National Health Law Program, June 2001, p. 3.17.
[47] *State Medicaid Manual*, § 3620.1.
[48] *State Medicaid Manual,* § 3625.
[49] Centers for Medicare and Medicaid Services, *State Medicaid Manual*, Chapter VII, § 3621, Rev. 67.
[50] *State Medicaid Manual*, § 3623.1
[51] *State Medicaid Manual*, § 3623.1.
[52]http://www.ssa.gov/notices/supplemental-security-income/text-understanding-ssi.htm#resource
[53] *State Medicaid Manual,* § 3627.
[54] Robert L. Mollica and Robert Jenkens, *State Assisted Living Practices and Options: A Guide for State Policy Makers*, National Academy for State Health Policy and NCB Development Corporation, September 2001.
[55] *An Advocate's Guide to the Medicaid Program*, pp. 3.17-18.

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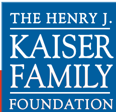

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